U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 09 August 2004

CASE NO. 2003-LHC-2874

OWCP NO. 02-111664

In the Matter of:

ROY BALLARD,
Claimant,

vs.

MORRISON CONSTRUCTION,
Employer,

and

ACE, U.S.A.,
Carrier.

Appearances:

James Woods, Esq.
For Claimant

Keith Flicker, Esq.
For Employer / Carrier

BEFORE: Anne Beytin Torkington
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

Roy Ballard (”Claimant”) brings this claim under the Longshore and Harbor Workers’ Compensation Act, as amended (hereinafter “the Act” or the “Longshore Act”), 33 U.S.C. § 901 *et seq*. against Morrison Construction Company (“Employer”) and its carrier ACE, U.S.A. A formal hearing was held in Seattle on March 8, 2004, at which both parties were represented by counsel and the following exhibits were admitted into evidence: Administrative Law Judge’s

Exhibits ("ALJX") 1, 1A, 2 and 3,[1] Claimant's Exhibits ("CX") 1, 2, 6 and 7; and Employer/Carrier's Exhibits ("RX") A through D. Tr. at 6-11. Employer submitted Dr. Reese's deposition on April 13, 2004 and it is hereby admitted as RX-E, pp. 1-52.

Employer's Post-Trial Brief was received on May 12, 2004 and Claimant's Post-Trial Brief was received on May 17, 2004. These are hereby admitted as ALJX-4 and ALJX-5.

Stipulations relevant to this proceeding are contained in the order issued October 31, 2002, ALJX-3.

Issue in Dispute

> Must Employer pay for surgery to repair nerve damage to Claimant's left foot under Section 7(a) of the Act, 33 U.S.C. Sec. 907(a)?

SUMMARY OF DECISION

Claimant has demonstrated that the proposed surgery to his left foot is reasonable and necessary. Therefore, Employer is required to pay for it under Section 7(a) of the Act.

SUMMARY OF EVIDENCE

Claimant's Testimony

Claimant testified at trial on March 8, 2004. Claimant was born on March 15, 1945. Tr. at 17. Claimant worked as a carpenter for Morrison Construction and on June 23, 1993, injured his left foot while doing construction at an embassy in The Hague, Netherlands. Tr. at 18. Steel plates weighing approximately 3,000 pounds fell on Claimant's left foot, resulting in a crushing injury. Tr. at 19. Claimant received treatment for his big toe while in the Netherlands, and then returned to the United States. Tr. at 20. Subsequently, Claimant's big toe was amputated. Tr. at 21. Claimant then suffered from reflex sympathetic dystrophy and experienced pain transferred from his left foot to his right foot. Tr. at 21. Following the amputation of his left big toe, Claimant underwent four surgeries to treat the nerve pain in his foot[2] and three were performed by Dr. Steven Miller, a podiatrist. Tr. at 22-24. Claimant states that he has not experienced any relief from the surgeries. Tr. 24. Claimant testified that he continues to suffer from chronic pain. Tr. at 29. Claimant worked with a pain clinic to treat the chronic pain in his left foot. Claimant stated that the clinic told him to "work through the pain." Tr. at 53.

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[1] Administrative Law Judge's Exhibits are Claimant's Pre-Trial Statement ("ALJX-1"), Claimant's hearing brief ("ALJX-1A") and Employer's Pre-Trial Statement ("ALJX-2"), and order granting 8(f) relief and stipulations of settlement issued October 31, 2002 ("ALJX-3"). See Transcript, ("Tr.") at 5.

[2] Stipulation of the Parties, Tr. 28.

After a consultation with his treating physician, Dr. Miller, Claimant was referred to Drs. Lee Dellon and Christopher T. Maloney to explore surgical options. Tr. at 29-30. In the alternative, Dr. Miller suggested amputating Claimant's leg to reduce the pain. Tr. at 30. In April 2002, Dr. Dellon conducted tests and concluded that Claimant was a candidate for surgery. Tr. at 30, 45-46. Claimant stated that Dr. Dellon recommended two separate surgeries. Tr. at 46. The first procedure would focus on the top of the stub, the outside of the ankle, and the inside of the ankle and higher on the calf. Tr. at 46. If the first procedure did not resolve the pain, the second procedure would focus on the inside of the heel and the bottom of the foot. Tr. at 46. In 2003, Dr. Christopher T. Maloney (an associate of Dr. Dellon) recommended the same procedures. Tr. at 47.

Claimant stated that Drs. Dellon and Maloney did not guarantee complete relief, but rather a reduction in pain. Tr. at 47-48. Claimant understands that even after surgery, he may experience little or no relief from pain. Tr. at 48-49.

Claimant stated that he had initially scheduled the surgery after his consultation with Dr. Dellon in April 2002, but two weeks prior to the surgery, the insurance carrier refused to provide authorization. Tr. at 31.

In May 2003 in Seattle, Claimant visited Dr. Reese.[3] Dr. Reese told claimant that in his opinion, the surgery would not work. Tr. at 31-32.

Claimant testified that he experiences a sometimes dull, sometimes shooting pain in his left foot, with burning and throbbing. Tr. at 32. Claimant testified that sometimes his foot gets ice cold. Tr. at 32. Claimant testified that though he is able to care for himself, he experiences continuous pain. Tr. at 33. Claimant is retired and will not be returning to work. Tr. at 40-41. He is unable to sleep for more than an hour and a half at a time. Tr. at 57.

Claimant is currently taking Neurontin and Tylenol for the pain in addition to an anti-depressant and an anti-inflammatory drug. Tr. at 33-34. On cross-examination, Claimant stated that other than a special shoe that he wears on his left foot, he does not employ any other devices or aids for his left foot. Tr. at 38-39. He testified that he has not used a cane in three years. Tr. at 39.

Claimant testified that he visits Dr. Miller once every 6 months, and that it has been a year since his last visit. On cross-examination, Claimant stated that he currently has no future appointments scheduled with Dr. Miller, although he has a "call in for return," because he wishes to talk to Dr. Miller "about the surgery and . . . anything new that we could do on this." Tr. at 43-44.

[3] Dr. Reese is an independent medical examiner on behalf of Employer.

Dr. Harry Reese, M.D.

Dr. Reese testified on behalf of Employer by deposition on March 10, 2004, in Seattle, Washington. His deposition is at RX-E. Dr. Reese previously testified in this matter in April 2002. RX-E at 8.

Dr. Reese stated that he currently does not provide medical examinations for litigation purposes. RX-E at 8. In the past three years, ten percent or less of Dr. Reese's practice was composed of medical examinations for litigation purposes. RX-E at 8.

Dr. Reese is a board certified orthopedic surgeon practicing in Seattle, Washington, and operates a clinic specializing in wound care, which is the practice of healing diabetic ulcers on the body. RX-E at 5 and 7. Dr. Reese practiced foot surgery until 1991 or 1992, then left it to focus on medical evaluations performed in his clinic. RX-E at 38-40. Currently, Dr. Reese travels to nursing homes performing wound care surgeries and toe amputations bedside. RX-E at 7. Dr. Reese does not perform foot or ankle surgery in the operating room. RX-E at 40. Dr. Reese has never performed the surgery in question, nor has he witnessed that surgery being performed. RX-E at 40.

Dr. Reese examined Claimant on May 14, 2003 to assess the reasonableness and necessity of the recommended surgeries. RX-E at 10. The examination consisted of an interview with Claimant and a comprehensive orthopedic examination to evaluate the left foot. RX-E at 12. Dr. Reese ascertained Claimant's height, weight, usage of devices in shoes, stance and gait. RX-E at 12. Dr. Reese performed range of motion and muscle strength testing of Claimant's left foot and ankle. RX-E at 12-13.

Dr. Reese stated that as a result of the injury, Claimant's great toe from his left foot was amputated. RX-E at 17. Subsequently, Claimant had four additional nerve release procedures to control the pain in his left foot. *Id*. Dr. Reese noted that after the amputation, all subsequent procedures were performed by a podiatrist, Dr. Miller, and were all related to reducing Claimant's foot pain. RX-E at 19.

Post-amputation, Dr. Reese described the first procedure as a release of the tarsal tunnel. RX-E at 20. The second procedure was a surgical decompression of the neuromas around the amputation stump. Dr. Reese described a neuroma as the tumorous scarring at the end of the nerves that have been cut during an amputation. These neuromas can create varying degrees of pain in different individuals. Tr. 22. The second and third procedures cut the nerves further back and buried them in muscle or bone, to prevent the nerves from forming painful neuromas. RX-B at 10 and E at 22. The fourth procedure excised an entrapped branch of the medial plantar nerve in Claimant's left foot. RX-E at 21. The final two surgeries were performed in July 1999. RX-B at 10. Dr. Reese stated according to Claimant, none of the procedures have provided any lasting pain relief. RX-E at 23.

Dr. Reese testified that he believes Claimant's pain is caused by reflex sympathetic dystrophy or a complex regional pain syndrome, and that Claimant did not have a definable anatomical aberration but a "chronic pain state that had developed in the foot." RX-E at 24.

Dr. Reese described the procedure recommended by Dr. Dellon and Dr. Maloney. The surgery would consist of exploring the nerve up the Claimant's leg, but short of the knee, releasing all common peroneal nerves at the fibula neck and redoing the carpal tunnel release. Additionally, the surgery would explore the calcaneal nerve for tight tunnels. Similar to the other procedures, Dr. Dellon and Dr. Maloney would implant the nerves. Dr. Reese summarized the proposed surgeries as "going deeper and tak[ing] the nerves back further." RX-E at 27. Dr. Reese based these statements on Drs. Dellon and Maloney's medical evaluations of Claimant. RX-E at 26.

Dr. Reese stated that the proposed surgeries would not eliminate Claimant's chronic pain condition. Dr. Reese stated that the rationale for the surgery assumes that the pain generators are the neuromata that are formed when the nerves are cut. Since Dr. Reese did not locate an anatomical aberration in Claimant's left foot, he does not believe that the surgery will alleviate Claimant's pain. RX-E at 32. He concluded that the proposed surgery was both unnecessary and unreasonable because chronic pain cannot be treated by surgery. RX-E at 31-32.

Dr. Reese testified that he was familiar with Dr. Dellon's work in part because he had previously been involved with litigation concerning peripheral nerve surgery. RX-E at 35. Even though he does not believe that the surgery will benefit Claimant, Dr. Reese stated that Dr. Maloney and Dr. Dellon are skilled physicians. RX-E at 41-42. On cross-examination, Dr. Reese agreed that there was room for a difference of opinion between physicians regarding surgical recommendations. RX-E at 37.

Dr. Lee Dellon, M.D.[4]

Dr. Dellon is a board certified plastic and hand surgeon. CX-6 at 11. Dr. Dellon practices in Baltimore, Maryland and Tucson, Arizona. CX-6 at 9. Dr. Dellon is a graduate of Johns Hopkins University School of Medicine and has completed residencies in general, plastic and hand surgery. CX-6 at 9. Dr. Dellon holds the positions of Professor of Plastic Surgery (from 1994 to present), Professor of Neurological Surgery (from 1994 to present) at Johns Hopkins University, Professor of Plastic Surgery and Neurosurgery (2000 to present) at the University of Arizona, and Professor of Surgery (Plastic Surgery) (2001 to present) at the University of Maryland. CX-6 at 10. Dr. Dellon is the recipient of several awards in the field of surgery. CX-6 at 11-13. In addition, Dr. Dellon has published extensively on the subject of hand and nerve surgery, and specifically, peripheral nerve surgery; his curriculum vitae contains a list of 325 publications, including three books. The most recent publication listed was published in December 2002. CX-6 at 14-41.

Summary of Dr. Dellon's Diagnosis and Recommended Treatment

Dr. Dellon diagnosed Claimant with a recurrent neuroma of the superficial peroneal nerve as a result of his work injury. CX-1 at 1. Dr. Dellon found a visible bulge and pain near the lateral aspect of Claimant's leg approximately six centimeters proximal to the lateral maleolus causing pain to radiate into the dorsum of Claimant's foot. CX-1 at 1-2. Dr. Dellon

[4] Dr. Dellon submitted a medical report, CX-1 at 1-3.

recommends resecting the recurrent neuroma to a higher level and implanting it into the extensor hallucis longus muscle belly. CX-1 at 2.

Dr. Dellon also diagnosed Claimant with a neuroma of the terminal branch of the saphenous nerve. The treatment prescribed would resect the saphenous nerve proximal to the ankle and implant the nerve into the sub adjacent soleus muscle. CX-1 at 2.

In addition, Dr. Dellon diagnosed Claimant with recurrent neuromas of the medial plantar branches to the medial aspect of the big toe and the first and second common plantar digital nerves. Dr. Dellon recommends dissecting the preserving innervations to the rest of the bottom of the foot and implanting these into the muscles in the arch of the foot. CX-1 at 2.

Furthermore, Dr. Dellon diagnosed Claimant with residual compression of the branches of the tibial nerve. Dr. Dellon recommends a neurolysis of the tibial nerve and the distal medial and lateral plantar and calcaneal tunnels. CX-1 at 2.

Finally, Dr. Dellon diagnosed Claimant with compression of the common peroneal nerve at the fibular neck. Dr. Dellon recommends a neurolysis of the sciatic nerve common peroneal nerve at the fibular neck. CX-1 at 3.

Dr. Dellon stated he has conducted extensive testing on Claimant. The testing showed abnormal sensibility for the right medial plantar, medial calcaneal deep and superficial peroneal nerves, which Dr. Dellon wrote, was consistent with Claimant having shifted his weight to his right foot. CX-1 at 3.

Dr. Dellon recommended that prior to amputating Claimant's left leg, Claimant should have an attempt at additional pain relief by "decompression of the nerves." CX-1 at 3.

Dr. Dellon found Claimant's description of pain to be absent of any secondary motivations. Dr. Dellon found that Claimant was "sufficiently off of pain medication" and that narcotics were not an issue.[5] CX-1 at 1.

Dr. Christopher T. Maloney, M.D.[6]

Dr. Maloney is a board certified plastic surgeon and an associate physician in Dr. Dellon's practice. Dr. Maloney is a clinical assistant professor of surgery in various departments of the University of Arizona and the Director of the Wound Care Program at Kindren Hospital, Tucson, Arizona. Dr. Maloney has completed multiple residencies in different types of plastic surgeries since 1999. Dr. Maloney has published on topics relating to neuromas and pain. CX-7 at 42.

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[5] There is no apparent explanation for the inconsistencies between the Claimant's testimony and Dr. Dellon's medical evaluation with regards to Claimant's pain medication intake.

[6] Dr. Maloney submitted a medical report, CX-2 at 4-5.

Dr. Maloney's Diagnosis and Recommended Treatment

Dr. Maloney examined Claimant on February 11, 2003 and diagnosed him with multiple recurrent neuromas and nerve entrapment secondary to a severe work-related crush injury. CX-2 at 4-5. Specifically, Dr. Maloney diagnosed Claimant with:

1) Superimposed compression traction injury to the common peroneal nerve of the left lower extremity in the fibular neck area;
2) Recurrent tarsal tunnel release with entrapment of the medial and lateral plantar nerve and the calcaneal nerves of the left foot;
3) Recurrent neuroma of the medial plantar nerve;
4) Neuroma of the saphenous nerve;
5) Neuroma of the deep peroneal nerve;
6) Recurrent neuroma of the left superficial peroneal nerve. CX-2 at 5.

Dr. Maloney recommended the following treatment for Claimant:

1) Release his common peroneal nerve at the fibular neck area;
2) Redo tarsal tunnel release with release of the medial and plantar tunnels and exploration of the calcaneal nerve for any tight tunnels;
3) Resection of the medial plantar nerve with implantation deep in the arch of his foot;
4) Resection of the saphenous nerve at the distal lower extremity with implantation into the deep muscles of the leg;
5) Excise recurrent neuromas of the superficial and deep peroneal nerve with a fasciotomy and implantation deep in the muscle of the left lower extremity.

Dr. Maloney stated that procedure #5 has the best chance of relieving the Claimant's pain. CX-2 at 5. Dr. Maloney continued that Claimant had an "excellent chance of reducing his pain, but a small chance of eliminating pain" with the aforementioned operations. Dr. Maloney found that Claimant was not on narcotics and was otherwise functioning well. CX-2 at 5.

ANALYSIS

Employer contends that funding a fifth nerve surgery to reduce Claimant's foot pain is unreasonable and unnecessary. Employer claims the proposed surgery will not reduce Claimant's pain because the pain is not caused by the neuromatas in his left foot, and the four prior surgeries have failed to reduce his pain.

Section 7(a) of the Act, 33 U.S.C. Sec. 907(a), states that "[t]he employer shall furnish such medical, surgical, and other attendance or treatment . . . for such period as the nature of the injury or the process of recovery may require." Section 7 requires the employer to furnish the injured employee with medical care that is reasonable and necessary. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). The claimant establishes a *prima facie* case when a licensed physician states that the treatment is necessary for a work-related condition. *Turner v. Chesapeake & Potomac Telephone Co.*, 16 BRBS 255 (1984).

When considering medical evidence concerning a worker's injury, a treating physician's opinion is entitled to special weight. *Amos v. Director*, OWCP, 153 F.3d 1051 (9th Cir. 1998). However, a treating doctor's opinion is not necessarily conclusive regarding a claimant's physical condition or the extent of his disability. *See Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989); *Amos*, 153 F.3d at 1054 (special weight standard limited to treating doctor's opinion regarding treatment). Moreover, the court may reject the opinion of a treating physician which conflicts with the opinion of an examining physician, if the decision sets forth specific, legitimate reasons for doing so that are based on substantial evidence in the record. *Magallanes*, 881 F.2d at 751. In *Amos*, the Ninth Circuit found that the opinion of the claimant's treating physician was entitled to special deference, as long as the opinion was not shown "by the testimony of the . . . [Employer's] doctors to be unreasonable . . . ." *Amos*, 153 F.3d at 1054. The Ninth Circuit held that as long as the treatment recommended by the claimant's treating doctor was not unreasonable, the patient "has the right to chart his own destiny." *Id.*

Thus, in the instant case, it is Employer's burden to demonstrate that the treatment recommended by Drs. Dellon and Maloney is unreasonable. Dr. Reese, Employer's doctor, testified:

> In my medical opinions [sic] these surgeries would not eliminate this worker's chronic pain condition . . . . One of the things that we have come to appreciate is that in a chronic pain state there is no indication for surgical intervention as a treatment modality. That the simple cutting away of nerves won't make the chronic pain state resolve. RX-E at 30.

In his testimony, Dr. Reese stated that he felt the proposed surgery was unreasonable and unnecessary. RX-E at 31. After examining Claimant, Dr. Reese stated that his pain stems from the central nervous system and is felt in his extremity (foot). RX-E at 32. Dr. Reese opined that there was no acute anatomical aberration. He concluded that an operation affecting the neuromata in Claimant's foot would have no effect on the pain he experiences, and is therefore unreasonable and unnecessary. It is Dr. Reese's opinion that even an amputation of Claimant's leg will not lessen his pain. RX-E at 32.

Drs. Maloney and Dellon have a different diagnosis: Claimant's pain is caused by the neuromata in his foot, and this proposed surgery has a chance of reducing Claimant's pain. Unlike Dr. Reese, Dr. Dellon found anatomical aberrations in the Claimant's left foot after examination. Dr. Dellon found a visible bulge and pain near the lateral aspect of Claimant's leg approximately six centimeters proximal to the lateral maleolus, which he believed was causing pain to radiate into the dorsum of Claimant's foot. CX-1 at 1-2. Additionally, both physicians felt that the recommended procedures had a good chance of reducing Claimant's foot pain. Dr. Maloney opined that Claimant had an "excellent chance of reducing his pain, but a small chance of eliminating pain" with the aforementioned operations. CX-2 at 5. Dr. Dellon suggested that "prior to amputating the left leg below the knee, he [Claimant] should have an attempt at additional pain relief by decompression of the nerves . . . ." CX-1 at 3. Dr. Maloney and Dr. Dellon are recognized peripheral nerve specialists. In addition, both physicians, and particularly Dr. Dellon, have published widely on the topic of nerve injuries. CX-6 at 14-41 and CX-7 at 42-43.

To reject the treating physician's opinion, the ALJ must "'make findings setting forth specific, legitimate reasons for doing so that are based on substantial evidence in the record.'" *Winans v. Bowen*, 853 F.2d 643, 647 (9th Cir.1987) (*Winans*), quoting *Sprague*, 812 F.2d at 1230; see also *Murray v. Heckler*, 722 F.2d 499, 502 (9th Cir.1983) (*Murray*) (adopting this rule). In this case, Dr. Miller treated Claimant after his initial toe amputation, and subsequently referred him to Dr. Dellon, who recommended surgery. Claimant has not visited Dr. Miller in approximately one year, and has no plans for further treatment from Dr. Miller. Tr. at 43-44. Thus, since Drs. Dellon and Maloney are the only physicians Claimant is in contact with they are considered his treating physicians.

Employer has been unable to demonstrate that the opinions of treating physicians Dellon and Maloney are unreasonable. Employer has demonstrated that Dr. Reese differs in his diagnosis of the source of Claimant's pain, but this does not mean that the recommended surgery by Drs. Dellon and Maloney is unreasonable or unnecessary. Dr. Reese is not a specialist in this field of surgery. He has never performed nor witnessed the recommended surgery. In addition, under cross–examination, Dr. Reese admitted that Dr. Maloney and Dr. Dellon are skilled physicians and that the course of treatment they recommended can be attributed to differing diagnosis. RX-E at 41-42. Employer claims that since Claimant's four prior nerve surgeries have been failures, a fifth nerve surgery is unreasonable and doomed to failure. The evidence does not support Employer's statement. The surgery recommended by Drs. Dellon and Maloney can be sufficiently distinguished from Claimant's prior surgeries. Even Employer's expert witness, Dr. Reese, distinguished the surgeries in his deposition by stating that the fifth surgery was similar, but "more proximal; proximal meaning closer to the center of the body." RX-E at 27. Employer has not provided specific, legitimate reasons as to why the recommendations of Drs. Dellon and Maloney should be disregarded. Therefore, Employer has not demonstrated that the proposed surgery is unreasonable or unnecessary.

Even if Drs. Dellon and Maloney are not considered to be Claimant's treating physicians, there is no reason to discredit their opinions and accept Dr. Reese's. Drs. Dellon and Maloney are experts in the field of nerve repair, and have published extensively on the topic. See CX-6 at 9-41 and CX-7 at 42-43. Dr. Reese is neither a specialist in the field of nerve damage nor does he perform surgery other than toe amputations.

"When a patient is faced with two or more valid medical alternatives, it is the patient, in consultation with his own doctor, who has the right to chart his own destiny." *Amos*, 153 F.3d at 154. In this case, Drs. Dellon and Maloney, and Dr. Reese have provided Claimant with differing diagnoses and valid treatment alternatives. It is Claimant's decision, in consultation with his treating physicians, to choose the treatment alternative he prefers. Claimant has made his decision and it is not an unreasonable one. Therefore, it is Employer's obligation to pay for the surgery.

Employer has failed to meet its burden of demonstrating that the recommended surgery is unreasonable or unnecessary. Therefore, Employer must pay for Claimant's proposed nerve surgery.

CONCLUSION

Claimant has demonstrated that the proposed surgery to his left foot is reasonable and necessary. Therefore, Employer is required to pay for it under Section 7(a) of the Act.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, and based upon the entire record, I issue the following order:

1. Employer shall pay for Claimant's proposed surgery to his left foot.

2. Counsel for Claimant is hereby ordered to prepare an Initial Petition for Fees and Costs and directed to serve such petition on the undersigned and on the counsel for Employer within 21 days of the date this Decision and Order is served. Counsel for Employer shall provide the undersigned and Claimant's counsel with a Statement of Objections to the Initial Petition for Fees and Costs within 21 days of the date the Petition for Fees is served. Within ten calendar days after service of the Statement of Objections, counsel for Claimant shall initiate a verbal discussion with counsel for Employer in an effort to amicably resolve as many of Employer's objections as possible. If the two counsel thereby resolve all of their disputes, they shall promptly file a written notification of such agreement. If the parties fail to amicably resolve all of their disputes within 21 days after service of Employer's Statement of Objections, Claimant's counsel shall prepare a Final Application for Fees and Costs which shall summarize any compromises reached during discussion with counsel for Employer, list those matters on which the parties failed to reach agreement, and specifically set forth the final amounts requested as fees and costs. Such Final Application must be served on the undersigned and on counsel for Employer no later than 30 days after service of Employer's Statement of Objections. Within 14 days after service of the Final Application, Employer shall file a Statement of Final Objections and serve a copy on counsel for Claimant. No further pleadings will be accepted, unless specifically authorized in advance. For purposes of this paragraph, a document will be considered to have been served on the date it was mailed. Any failure to object will be deemed a waiver and acquiescence.

3. The parties will immediately notify this office upon filing an appeal, if any.

IT IS SO ORDERED.

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ANNE BEYTIN TORKINGTON
Administrative Law Judge